

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: <p align="center">02-16</p>	2. STATE <p align="center">Louisiana</p>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <p align="center">September 7, 2002</p>	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: <p>42 CFR 447.253 and 447.45</p>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2002</u> <u>\$0.00</u> b. FFY <u>2003</u> <u>\$0.00</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <p>Attachment 4.19-A, Item 1, Page 10c Attachment 4.19-A, Item 1, Page 10j(2)</p>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <p>Same (TN 01-10) Same (TN 01-10)</p>

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to clarify rules governing DSH payment methodologies regarding final payments and adjustments.

11. GOVERNOR'S REVIEW (Check One):

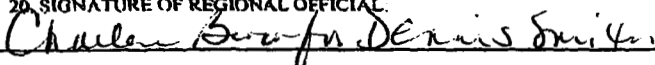
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☒ OTHER, AS SPECIFIED: The Governor does not review state plan material☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: <p>State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030</p>
13. TYPED NAME: <p>David W. Hood</p>	
14. TITLE: <p>Secretary</p>	
15. DATE SUBMITTED: <p>September 23, 2002</p>	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: <p><i>September 27, 2002</i></p>	18. DATE APPROVED: <p><i>November 1, 2002</i></p>
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: <p><i>September 7, 2002</i></p>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <p><i>Charlene Brown</i></p>	22. TITLE: <p><i>Deputy Director, CMSO</i></p>

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-A
Item 1, Page 10e

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE

Item I.D.3.a(3) for public state-operated hospitals

Item I.D.3.b(4) for small rural hospitals

Item I.D.3.c(3) for large public non-state hospitals

Item I.D.3.d(6) for all other hospitals

- b. Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.
- c. DSH payments to a hospital determined under any of the methodologies below shall not exceed the hospital's net uncompensated cost as defined in Item I.D.2.f. for the state fiscal year to which the payment is applicable.
- d. Qualification is based on the hospital's latest filed cost report. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports shall be assumed to be ineligible for disproportionate share payments.

Hospitals are notified by letter at least 60 days in advance of calculation of the DSH payment to submit documentation required to establish DSH qualification. Required documents are: 1) obstetrical qualification criteria form; 2) low income utilization revenue calculation; 3) Medicaid cost report; 4) uncompensated cost calculation. Only hospitals which have submitted the qualification documentation by the deadline stated in the notification letter will be considered for disproportionate share payments.

After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments for non-state operated hospitals even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

TN# 02-16
Supersedes

Approval Date

NOV 1 2002

Effective Date

SEP 7 2002

TN# 01-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-A
Item 1, Page 10j(2)

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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this pool of hospitals. If the cost reporting period is not a full period (twelve months), actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

- 4) A pro rata decrease necessitated by conditions specified in I.D.2.a. above for hospitals described in this section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying hospitals in this section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount. No additional payments shall be made after the final payment for the state fiscal year is disbursed by the Department. Recoupments shall be initiated upon completion of an audit if it is determined that the actual uncompensated care costs for the state fiscal year for which the payment is applicable is less than the actual amount paid.

TN# 02-16

Supersedes

TN# 01-10

Approval Date

NOV 11 2002

Effective Date

SEP 7 2002